DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1942

Registration District No. 3-82

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14998

Primary Registration District No. 6-779

Registrar's No. 33

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Monroe

(b) City or town: Jackson Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6 MI S.E. of PARIS
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 10 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO. (b) County: MONROE 69

(c) City or town: RURAL 0
(If outside city or town limits, write "RURAL")

(d) Street No.: 6 MI. SE. OF PARIS 0
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: GERTRUDE ISABELLE MARTIN

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: SINGLE

6. (b) Name of husband or wife: ✓

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: FEB. (Month) 17, (Day) 1864 (Year)

8. AGE: Years 78 | Months 2 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace: ONEIDA Co. (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business: —

FATHER
12. Name: CLARK H. MARTIN
13. Birthplace: — (City, town, or county) N.Y. (State or foreign country)

MOTHER
14. Maiden name: HARRIET A. HICKS
15. Birthplace: — (City, town, or county) N.Y. (State or foreign country)

16. (a) Informant: William L. Martin
(b) Address: Paris, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: MAY 9 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: LODA, ILL.

18. (a) Signature of funeral director: Speck & Bailey
(b) Address: Paris, Mo.

19. (a) 5-7-1942 (Date received local registrar) (b) E. H. Agnew (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day May year 1942 hour 8 (?) minute 0 a.m.

21. I hereby certify that I attended the deceased from — , 19..., to — , 19...;
that I last saw her alive on — , 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death: unknown — Duration: unk.

Due to: Has had some trouble with heart in the

Due to: past several years. ✓

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:
Of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury: 3

23. Signature: W. T. Turner Coroner
Address: Madison Mo. Date signed: 5/7/42

1274 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-42-987
Date Filed MAY 14 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
0M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14998

Registration District No. 582 Primary Registration District No. 3779 Registrar's No.

1. PLACE OF DEATH:

(a) County: Monroe

(b) City or town: — (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: — (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether years, months or days)

In this community: 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Monroe

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No.: — (If rural, give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country: —

3. (a) PRINT FULL NAME: Gertrude G. Martin

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex:

5. Color or race:

6. (a) Single, widowed, married, divorced:

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day: hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

12. Name:

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name:

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant:

(b) Address:

17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 7 year: 1942 hour: minute: a. m.

21. I hereby certify that I attended the deceased from: , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death: unknown

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: T. R. Turner Coroner (M.D. or other)

Address: Date signed:

SUPPLEMENTARY

Joan